Bicester Dental Centre

St Georges Barracks, Arncott, Oxfordshire, OX25 1PP

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Are services safe?	**Action required**	x
Are services effective?	**No action required**	✓
Are services caring?	**No action required**	✓
Are services responsive?	**No action required**	✓
Are services well led?	**Action required**	x

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of Bicester Dental Centre on 1 July 2025. We gathered evidence remotely and undertook a visit to the practice.

As a result of the inspection, we found the practice was effective, caring and responsive in accordance with the Care Quality Commission (CQC's) inspection framework. We found that action was required to ensure a safe and well-led service was being provided.

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the observations and recommendations within this report.

This inspection is one of a programme of inspections that CQC will complete at the invitation of the DMSR in their role as the military healthcare regulator for the DMS.

Background to this practice

Located in Oxfordshire and part of the Defence Primary Healthcare (DPHC) Dental Central and Wessex region, Bicester Dental Centre is a 2-chair practice providing a routine, preventative and emergency dental service to a military patient population of approximately 800. This includes patients from 2 barracks in Bicester and a small number from Kineton. The dental centre is co-located with the medical centre and is situated on the first floor of the building.

The practice is open Monday to Wednesday from 08:00-16:45 hours and is closed on Thursdays and Fridays. Daily emergency treatment appointments are available. Access to a hygienist at RAF Benson (approximately 45 minutes by car) is facilitated through referral by a dental officer. A regional emergency rota provides access to a duty dentist when the practice is closed. A number is provided for patients to call a dentist; following triage, the patient can be seen at a military dental centre.

Minor oral surgery referrals are made to an Intermediate Minor Oral Surgery Service that can be provided at Lyneham Dental Centre. Secondary care support is available from the local NHS hospital trust (John Radcliffe Hospital in Oxford) for oral surgery and oral medicine. DPHC's Defence Centre for Rehabilitative Dentistry is also used for other referrals.

The staff team at the time of the inspection

Dentists Dentist (locum or visiting military dentist from within the region)	1 military Senior Dental Officer (SDO) (shared with Benson Dental Centre whilst a new SDO is being recruited, working 2 days a week at Bicester) Ad hoc arrangements are made in line with forecast requirement and availability
Dental nurses	1 civilian full-time 1 locum part time (dependant on the number of clinics held)
Practice management	1 civilian practice manager

Our Inspection Team

This inspection was undertaken by a CQC inspector, a dentist specialist advisor and practice manager/dental nurse specialist advisor. A newly recruited specialist advisor shadowed the inspection as part of their induction.

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the SDO, dental nurses and the practice manager. We looked at practice systems, policies, standard operating procedures and other records related to how the service was managed. We also checked the building, equipment and facilities, and reviewed feedback from patients who were registered at the dental centre.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- The practice used the DMS-wide electronic system for reporting and managing incidents, accidents and significant events. Staff awareness and formal reporting were highlighted as areas for minor improvement.
- Systems to support the management of risk, including clinical and non-clinical risk were in place but required regular review and actions identified were not being completed in a timely manner.

- Suitable safeguarding processes were established, and staff understood their responsibilities for safeguarding adults.
- The required training for staff was up-to-date (in progress for a new member of staff) and they were supported with continuing professional development.
- The clinical team provided care and treatment in line with current guidelines. Record keeping was of a high standard.
- Staff treated patients with dignity and respect and took care to protect patient privacy and personal information.
- The appointment and recall system was not meeting patients' needs and the requirements of the Chain of Command due to the lack of clinics.
- Leadership at the practice was inclusive but with time constraints and the prioritisation of treating patients, there was insufficient capacity to provide effective governance.
- Staff worked well as a team to try and meet the challenges. Their views about how to develop the service were considered internally but requests for additional clinical hours were not being met.
- An effective system was in place for managing complaints.
- Medicines and life-saving equipment were available in the event of a medical emergency. We highlighted a number of missing items that were added after the inspection. Arrangements for temperature control and tamper tags were also addressed after the inspection.
- Staff worked in accordance with national practice guidelines for the decontamination of dental instruments.
- Systems for assessing, monitoring and improving the quality of the service were in place. Staff made changes based on lessons learnt and patient feedback.

We recommend to the unit:

- Issues identified in the latest fire risk assessment and legionella risk assessment require action, of particular note, in the areas that have been categorised as high priority.
- Modify the location of power switches in clinic 2 to ensure staff are safe from the potential impacts of radiation exposure.

We recommend to Defence Primary Healthcare:

- Issue clear guidance to dental teams with regard to the key changes to Health Technical Memorandum 07-01 and what this means in practice.
- Review the leadership capacity and continuity together with staffing levels giving consideration to the number of clinics actually being provided and the lack of ad hoc support for when the SDO is absent.
- Review the arrangements for patients to be seen at other dental centres within the region and ensure there is agreement with the Chain of Command.

We recommend to the practice:

- Strengthen arrangements for legionella monitoring.
- Direct reference to the management of risk around the dental centre compressor should be made within the fire safety risk assessment. Staff from the dental team should be able to access this area as required.
- Ensure clinical waste management processes are fully effective in providing a traceable record of waste removal and disposal.
- Strengthen governance processes to include:
    - minutes of meeting include a record of lessons learnt and actions following a significant event review
    - staff are aware of their legal responsibilities for injury reporting and duty of candour
    - the regular review of the risk register and risk assessments to account for when the ownership of risk is transferred
    - a protocol and monitoring of fridges used to store medicines
    - completion of clinical audit.

Mr Rob Middlefell BDS

CQC's National Professional Advisor for Dentistry and Oral Health

Our Findings

Are Services Safe?

Reporting, learning and improvement from incidents

The Automated Significant Event Reporting (ASER) DMS-wide system was used to report, investigate and learn from significant events and incidents. All staff had access to the system to report a significant event. The staff team completed ASER training in April 2025, and this was recorded on the training log (links were sent to any staff member unable to attend). Staff we spoke with were clear in their understanding of the types of significant events that should be reported, including good practice and near misses. A record was maintained of all ASERs, which was categorised to support identification of any trends and displayed on a dedicated notice board.

There had been 2 ASERs recorded in the previous 12-months. Staff demonstrated that they were familiar with the processes for effective management and the implementation of any changes from lessons learnt. However, minutes of the practice meeting where the most recent ASER was discussed did not include a record of the lessons learnt. Significant events were a standing agenda item at the monthly practice team meeting. Staff unable to attend could review records of discussion, minutes of these meetings were held in a shared electronic folder (known as SharePoint).

Staff related accidents and incidents were reported via ‘MySafety’ process.

Staff were aware when to report incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). However, not all staff were sure of their responsibilities for reporting incidents and how to report.

Alerts were included on the ‘direction and guidance’ email that could be accessed by all staff. Regional Headquarters (RHQ) had a centralised system for the management of national patient safety and medicines alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA) and the Department of Health Central Alerting System (CAS). Alerts were acknowledged as read and the practice were required to acknowledge receipt and input actions completed into a regional register. Copies were shared with staff using a hard copy form. This was signed by individual staff members to confirm they had read and understood the alert. The practice planned to share alerts electronically so electronic signatures of receipt could be requested. The SDO monitored the safety alerts in the absence of the practice manager.

Reliable safety systems and processes (including safeguarding)

The SDO was the safeguarding lead and had level 3 training. The safeguarding policy, procedure and personnel in key roles were displayed on the patient information noticeboard. The practice manager and locum nurse had also completed level 3 safeguarding training; the dental nurse had completed level 2. Staff were aware of their responsibilities if they had concerns about the safety of patients who were vulnerable due to their circumstances.

In relation to the management and support for vulnerable patients, the SDO and practice manager had close links with both the executive team and medical centre team. At the time of the inspection, there were no registered patients under the age of 18. A search was carried out every 6-months to capture any new patients under 18. The Unit would inform the dental centre and chaperone any patients aged under 18 to the dental centre (the patient was then given the choice of having a chaperone during their consultation). Vulnerable patients were discussed at the Commanders Executive Meeting attended by the practice manager. Safeguarding information was displayed including the practice policy and contact details for making referrals to the local safeguarding team.

The SDO understood the Duty of Candour (DoC) principles, and this was evident in patient records when treatment provided was not in accordance with the original agreed treatment plan. Although a register was in place, there were no entries and staff had not received training. We found some staff members were unsure of the DoC requirements. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

The dentists were always supported by a dental nurse when assessing and treating patients. A chaperone policy was in-date and displayed on the corridor noticeboard as well as on the patient information noticeboard in the waiting area. Although lone working was not normal practice, there was a lone working risk assessment which required any individual working alone to inform the guardroom and the medical centre (the risk assessment required a signature from the SDO). Out-of-hours clinics were not hosted at Bicester so staff on call did not use the building when on duty. Each surgery room had a panic alarm button that allowed staff to call for assistance. The panic alarms were tested weekly and at the inspection. A sounding of the alarm would be heard at reception.

A whistleblowing policy was in place and displayed on the staff noticeboard. Staff had received training and said they would feel comfortable raising any concerns. Staff also had the option to approach the regional ‘Freedom to Speak Up Champion.’ Contact details were displayed on a poster displayed in reception.

A ‘raising concerns’ policy was in place and displayed on the patient information board. Staff also had the option to approach the regional ‘Freedom to Speak Up Champion.’ Contact details were available on SharePoint.

Dental dams were routinely used for restorative and endodontics (root canal treatment) in line with guidance from the British Endodontic Society.

A comprehensive business continuity/resilience plan (BCP) was in place and had last been reviewed in March 2025. The BCP set out how the service would be provided if an event occurred that impacted its operation. The plan included action to be taken in the event of staff shortages, loss of compressed air, temperature control (heating and cooling), adverse weather conditions and a pandemic alert. Key contacts listed on the plan included staff members, senior members of the regional team, nearby dental centres, the Quartermaster, Commanding Officer and the main guardroom. The BCP could be accessed remotely should access to the building be restricted. Testing had been carried out with a simulated exercise undertaken in June 2025. The exercise included an overview, summary and improvements identified as a result. The learning outcomes identified had yet to be actioned but had been discussed and included in the minutes of June’s practice meeting.

The BCP detailed cancellation, relocation and reopening protocols together with links to the Garrison BCP, major incident plan and disease control plans.

Medical emergencies

The medical emergency standard operating procedure from Defence Primary Healthcare (DPHC) was followed and the SDO was the resuscitation lead. Reviews of the emergency medicines were completed at headquarter level. The automated external defibrillator (AED) and emergency trolley was securely stored, as were the emergency medicines. A key was held in a key press within the guardroom and signed in and out to control and assign access. The code was changed regularly and had been done in the last 6-months. However, tamper tallies were not used to indicate when the emergency trolley had been used. Daily checks of the medical emergency kit were undertaken and recorded by the dental nurses who had been given specific training to undertake the role. However, a review of the records and the emergency trolley highlighted some gaps. Blunt ended scissors and a razor were added soon after the inspection and checks of the spillage kits added to the weekly check list. The trolley was stored in one of the surgeries which was temperature controlled, and all items were in-date. However, temperature checks were not carried out on the equipment and medicines.

All staff had received anaphylaxis and sepsis training, were aware of the signs of sepsis and information was displayed in the surgeries to support in recognising the symptoms. Staff were up-to-date with training and aware of medical emergency procedures. They knew where to find medical oxygen, emergency drugs and equipment training in managing medical emergencies, including emergency resuscitation and the use of the AED. The team completed basic life support, cardiopulmonary resuscitation and AED training annually. Training that used simulated emergency scenarios was undertaken 6-monthly.

First aid, bodily fluids and mercury spillage kits were available. A member of staff from the medical centre was the appointed first aider and there was a first aid station within the dental centre (situated in the practice manager's office). The medical practice was co-located (downstairs) so could easily be used to support with any first aid requirements.

Staff recruitment

The full range of recruitment records for permanent staff was held centrally. The practice manager had access to the DMS-wide electronic system so could demonstrate that relevant safety checks had taken place at the point of recruitment, including an enhanced Disclosure and Barring Service (DBS) check to ensure staff were suitable to work with vulnerable adults and young people. The DBS check was managed by station, and civilian personnel were checked every 3-years, military personnel every 5-years.

The practice manager monitored and maintained a register of staff members' General Dental Council registration status, indemnity cover and the relevant vaccinations required for their role.

Monitoring health & safety and responding to risks

A number of local health and safety (H&S) policy and protocols were in place to support with managing potential risk. The H&S policy statement was current and displayed in the

reception corridor and there was an H&S notice board furnished with the latest information. The safety, health, environment and fire (SHEF) team carried out a workplace health and safety inspection but not monthly checks despite being requested to by the practice manager. In addition, the practice manager was the named health and safety lead, and this was reflected in their terms of reference. The practice manager was a trained risk assessor and there was a set of risk assessments that included occupational stress, handling and disposing of clinical waste, working with trip hazards and lone working. These had not been reviewed by the new SDO, the last review was in December 2024 by the previous SDO.

The SHEF team carried out a fire risk assessment of the premises every 5-years with the most recent assessment undertaken in February 2022. The medical centre practice manager was the fire warden for the premises and the building custodian checked the fire system weekly with a record made in the fire logbook. Staff received annual fire training, and an evacuation drill of the building was conducted in May 2025. There was a fire safety noticeboard displayed in the reception corridor. Electrical equipment testing (previously PAT testing) had been carried out in line with policy. A review of the last fire risk assessment highlighted a number of outstanding actions. Radiant bar heaters remained in use despite being prohibited due to safety concerns (potential fire hazard) and environmental regulations (aimed at reducing carbon emissions and become more energy efficient). Additional signage was recommended and paving at the fire exit presented a trip hazard. These tasks had been allocated to the building custodian.

A Control of Substances Hazardous to Health (COSHH) risk assessment was in place and had been reviewed in March 2025. COSHH data sheets were held in a register which had been reviewed in March 2025. A log sheet was maintained of each hazardous product with links to the safety data sheets.

The practice followed relevant safety laws when using needles and other sharp dental items. A sharps policy was available and sharps boxes in clinical areas were labelled, dated and used appropriately. The ‘Insafe’ system was used to reduce the risk of sharps injuries and dentists disposed of the sharps they used. Staff had completed training on sharps injuries, which included how to manage injuries and the action to take post-incident. Sharps incidents were reported using the MySafety and/or ASER systems. DoC principles were followed if the sharps injury involved a patient. There had been no sharps injuries in the last 12-months. We highlighted that the poster to instruct on the first aid to be administered following a sharps injury (annex B of JSP 950 LFT 7-2-1) was not displayed in 1 of the surgeries.

We looked at the practice’s arrangements for the provision of a safe service. A risk register was in place and had been reviewed monthly by the previous SDO. Although a diarised reminder was in place, the risk register was yet to be reviewed by the acting SDO due to time constraints. The main issues identified were the fire doors not being compliant. This had been raised in December 2024 and was being followed up on the day of inspection by the SHEF team.

Infection control

The lead role for infection prevention and control (IPC) was vacant but interim support had been provided by the regional IPC lead. The IPC policy and supporting protocols took

account of the guidance outlined in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM 01-05) published by the Department of Health. All the staff team were up-to-date with IPC training and records confirmed they completed refresher IPC training every 6-months. IPC audits were undertaken annually and the most recent was undertaken in January 2025. However, there was no formal action plan produced as a result of the audit. Water quality was tested monthly using dip slides. A water evaluation survey carried out in May 2025 recommended a treatment to put in the water due to the contamination being greater than the acceptable limit for compliance. Although listed on the dental unit waterline records, no actions had been documented.

We checked the surgeries. They were clean, clutter free and met IPC standards, including the fixtures and fittings. Environmental cleaning was carried out by a contracted company twice a day and this included cleaning in between morning and afternoon clinics. The cleaning contract was monitored monthly by the practice manager and any issues were reported. The contract was also monitored by the Quartermaster. Any inconsistencies or issues were reported to the cleaning manager. The contractor provided a cleaning schedule but not the contract. However, the practice management were satisfied that the current contract was sufficient for the practice needs and deep cleaning arrangements were in place. The cleaning cupboard was tidy and well organised, and staff could access it if needed in between the routine daily cleaning. Suitable ventilation was provided by air conditioning units in each surgery.

Decontamination took place in a Central Sterile Services Department (CSSD) accessible from the surgeries. Sterilisation of dental instruments was undertaken in accordance with HTM 01-05. Records of validation checks were in place to monitor that the ultrasonic bath and autoclave were working correctly. Records of temperature checks and solution changes were maintained. Instruments and materials were regularly cleaned with arrangements in place to check materials to ensure they were in-date.

A detailed legionella risk assessment had been carried out by an external contractor in February 2025 and covered all the required areas. The assessment highlighted actions that included recommendations categorised as ‘high priority’ with a completion date within 3-months. These included defining individual responsibilities and conducting training for those with lead roles and investigation of the hot water return temperature being below 55˚C. The practice manager was unsure what actions had been completed. They were experiencing difficulties accessing the information and did not receive confirmation of the action taken when the water temperatures had fallen outside of the parameters. Water temperatures were being received sporadically, and some requests had not been responded to.

Arrangements were in place for the segregation, storage and disposal of clinical waste products, including amalgam, sharps, extracted teeth. The clinical waste bin, external of the building, was locked, secured and away from public view. Clinical waste was collected weekly, and consignment notes were provided by the contractor. Waste transfer notes were transferred to the medical centre. However, we identified that the arrangements were not being followed. Clinical waste was not being logged individually, quarterly reports were not being completed and there had not been any audit on waste collected. There was a clinical waste bag in an unused old bin behind the building, but it was not clear if this was

from the medical centre or dental centre. We highlighted that arrangements should be strengthened with clarity on which waste was from the dental centre, and which was from the medical centre. Destruction certificates should be obtained for best practice despite the waste removal being carried out by a licensed contractor. Following some key changes to the HTM 07-01 in December 2024, DPHC practices await guidance from DPHC around the treatment of clinical waste (the use of tiger bags versus orange bags and single-use versus reusable aspirator tips).

Equipment and medicines

An equipment log was maintained to keep a track of when equipment was due to be serviced. Any fault was recorded and pieces of equipment that could not be used were separated, labelled, boxed and quarantined in the laboratory. The autoclave and ultrasonic bath had been serviced in August 2024. However, the autoclave in the CSSD was not working and there was no signage to advise it was not in use. The servicing of all other routine equipment, including clinical equipment, was in-date in accordance with the manufacturer's recommendations. A separate log was maintained to record internal checks. Pharmaceutical fridges were defrosted and cleaned quarterly. A Land Equipment Audit (LEA) was completed in February 2025 and the recommendations made in the audit had been actioned. A register of equipment was maintained, and the most recent testing took place in January 2025.

An electronic log of prescriptions was maintained, and prescriptions were sequentially numbered and stored securely. Staff conducted monthly checks of sequential serialised number sheets to maintain traceability and accountability for any missing prescriptions. Minimal medicines were held in the practice. Patients obtained medicines through a local pharmacy. Medicines that required cold storage were kept in a fridge, but temperature checks were not recorded and there was no protocol in place. Glucagon (a medicine used to treat low blood sugar levels) was stored in the fridge in easy reach of the emergency trolley.

The practice had carried out an audit of antibiotic prescribing in March 2025. Although this is not a requirement, it is good practice and improves clinical oversight. Prescribing audits were on the practice audit plan but had not been prioritised due to the low numbers of items prescribed.

Compressor checks were not included in the fire risk assessment, which did not mention risks associated with compressed air. The next fire risk assessment was planned for February 2027, and the practice assured us that they would request for it to be included. An annual service of the compressor had been carried out in December 2024, and the certificate of inspection was in-date. Quarterly checks were carried out.

Radiography (X-rays)

The practice had suitable arrangements to ensure the safety of the X-ray equipment. The required information in relation to radiation was located in the radiation protection file. A Radiation Protection Advisor and Radiation Protection Supervisor (RPS) were identified for the practice. Signed and dated Local Rules were available in each surgery along with safety procedures for radiography. The Local Rules were updated in June 2025 and reviewed annually or sooner if any change in the policy was made, any change in

equipment took place or if there was a change in the RPS. A copy of the Health and Safety Executive notification was retained, and the most recent radiation protection advisory visit was in February 2022.

The isolator switch in surgery 2 was internal and staff would need to cross the beam in order to activate. This did not meet with health and safety requirements and as the isolation switch should be external to the rooms so staff would not need to walk through the beam to turn off the X-ray equipment.

Evidence was in place to show equipment was maintained annually, last done in August 2024. Staff requiring IR(ME)R (Ionising Radiation Medical Exposure Regulations) training had received relevant updates.

The dental care records for patients showed the dentists justified, graded and reported on the X-rays taken. The SDO carried out an intra-oral radiology audit every 6-months, the most recent was carried out in March 2025.

Are Services Effective?

Monitoring and improving outcomes for patients

The treatment needs of patients was assessed by the dentists in line with recognised guidance, such as National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network guidelines. Treatment was planned and delivered in line with the basic periodontal examination - assessment of the gums and caries (tooth decay). The dentists referenced appropriate guidance in relation to the management of wisdom teeth, considering operational need.

The dentists followed appropriate guidance in relation to recall intervals between oral health reviews, which were between 3 and 24-months depending on the patient's assessed risk for caries, oral cancer, periodontal and tooth surface loss. In addition, recall was influenced by an operational focus, including prioritising patients in readiness for rapid deployment.

We looked at patients' dental care records to corroborate our findings. The records included information about the patient's current dental needs, past treatment and medical history. The diagnosis and treatment plan for each patient was clearly recorded together with a note of treatment options discussed with the patient. Patients completed a detailed medical and dental history form at their initial consultation, which was verbally checked for any changes at each subsequent appointment. The dentists followed the guidance from the British Periodontal Society around periodontal staging and grading. Records confirmed patients were recalled in a safe and timely way.

The Senior Dental Officer (SDO) discussed the downgrading of personnel in conjunction with the patient's doctor to facilitate completion of treatment. The military dental fitness targets were closely monitored by the SDO and practice manager. We noted that performance of key performance indicators (KPIs) were below target levels but were in line with Defence Primary Healthcare (DPHC) averages. For example, 66% of patients were category 1 (had all operative treatment completed) and category 2 (treatment needed but not urgent and patient deployable). The plan was to catch up, but workforce gaps were preventing progress.

Health promotion & prevention

A proactive approach was taken in relation to preventative care and supporting patients to ensure optimum oral health. Although the position of health promotion lead was vacant, health education campaigns were refreshed in line with seasonal promotions and the DPHC calendar. It was planned for the dental nurse to be registered for the oral health education course, but this could not happen until they had completed 6-months in the role. The dental nurse was not trained in smoking cessation beyond 'Very Brief Advice on Smoking' (VBA) so patients were referred to the medical centre for this service (VBA is an evidence-based intervention designed to increase quit attempts among patients who smoke).

Dental care records showed that lifestyle habits of patients were included in the dental assessment process. The dentists and hygienist provided oral hygiene advice to patients on an individual basis, including discussions about lifestyle habits, such as smoking and

alcohol use. Oral health promotion leaflets were given to patients, and staff maintained a health promotion area in the patient waiting area. Displays were clearly visible and at the time of inspection included a 'be sugar smart' campaign to raise awareness of the amount of sugar in a select range of popular drink and food brands.

The dentists described the procedures they used to improve the outcomes for patients with gum disease. This involved providing patients with preventative advice, taking plaque and gum bleeding scores and recording detailed charts of the patient's gum condition. A mirror was used to show patients brushing, plaque or broken fillings.

Staffing

The induction programme included a generic organisation-level programme, and an induction tailored to the dental centre.

We looked at the organisational-wide electronic system used to record and monitor staff training and confirmed staff had undertaken the mandated training. The practice manager monitored the training plan and ensured it covers all the mandated requirements at the right times. The in-house training programme was detailed on a training register and discussed at practice meetings.

Dental nurses were aware of the General Dental Council requirements to complete continued professional development (CPD) over a 5-year cycle and to log this training. Staff had subscribed to a specialist online training provider for mandatory training that had been designed with the General Dental Council's requirements in mind, so that dental professionals could maximise CPD activities they chose to complete. All staff managed their own CPD requirements and had no issues accessing or completing the required work. Staff attended in-house and regional CPD events (included the DPHC webinar series) as required. Regional training was held monthly, and staff could access this training. Wednesday afternoons were protected, when possible, for mandatory training.

The staff members we spoke with voiced concern that the staffing establishment and skill mix was not appropriate to meet the dental needs of the patient population and to maximise oral health opportunities. In addition, the current arrangement was having a negative impact on staff wellbeing. The dental team were working to deliver the best level of care possible whilst responding to short notice rapid deployment pressures. However, the absence of a full-time SDO was given as a contributing factor in not meeting the KPIs. Resilience was to be provided within the region with the network of staff being used to provide services at Bicester as well as patients being seen at other dental centres within the region. However, this arrangement was not effective as requests for additional staff (notably dentists) were not being met and the Commanding Officer was not in agreement with patients being seen elsewhere. In addition, the practice manager was sent to work at other military dental centres when no dentist was available.

Working with other services

The SDO confirmed patients were referred to a range of specialists in primary and secondary care for treatment the practice did not provide. The dentists followed NHS guidelines, the Index of Orthodontic Treatment Need and Managed Clinical Network parameters for referral to other services. Patients could be referred to the John Radcliffe

Hospital in Oxford for secondary care. A spreadsheet was maintained of referrals and checked weekly. Each referral was actioned by the referring clinician once the referral letter was returned. Urgent referrals followed the 2-week cancer referral pathway.

The practice worked closely with the medical centre in relation to patients with long-term conditions impacting dental care. In addition, doctors had been instructed to remind the patient to make a dental appointment if it was noted on their record during a consultation that a dental recall was due. The Chain of Command was informed if patients failed to attend their appointment.

The practice manager attended the Commanders Monthly Case Review meetings at which the health and care of vulnerable and downgraded patients was reviewed. At these meetings, the unit were provided an update on the dental targets.

Consent to care and treatment

Clinical staff understood the importance of obtaining and recording patient's consent to treatment. Patients were given information about treatment options and the risks and benefits of these so they could make informed decisions. The dental care records we looked at confirmed this. Verbal consent was taken from patients for routine treatment. For more complex procedures, full written consent was obtained. Feedback from patients confirmed they received clear information about their treatment options.

Clinical staff had a good awareness of the Mental Capacity Act (2005) and how it applied to their patient population.

Are Services Caring?

Respect, dignity, compassion and empathy

We took into account a variety of methods to determine patients' views of the service offered at Bicester Dental Centre. The practice had conducted their own patient survey in using the General Practice Assessment Questionnaire (GPAQ) feedback tool. However, results had been collated by the previous Senior Dental Officer (SDO) and ceased when they left their post. The most recent data available was from feedback given between August 2023 and August 2024. A total of 137 responses had been captured and feedback was positive. A total of 99% of respondents said they were generally happy with their healthcare provided.

A total of 54 patients provided written feedback to us as part of this inspection by completing comment cards. All of the comments were positive and praised the staff for the level of care and service provided. The main themes were that staff were both friendly and informative.

For patients who were particularly anxious, the practice had an approach to understand the reason for anxiety, provided longer appointments and time to discuss treatment and invite any questions. Anxious patients were also highlighted on the clinical operating system (known as DMICP) with a 'Generalised Anxiety Disorder' or 'GAD' score (GAD is a self-report questionnaire used to screen and assesses for severity of anxiety). Relaxing music was played during consultations and patients were invited to bring their own music. Patients could also be referred for general anaesthetic, to a specialist or for treatment under sedation as a final option.

The waiting area for the dental centre was a small room and not of a design to promote confidentiality. To mitigate this, a sign was in place to advise patients to ask should they wish to have a conversation in private. Blinds had been removed during Covid-19 and there was no privacy screen on the windows. However, the rooms were on the first floor and there was little footfall behind the building, so it was unlikely a patient would be seen when having treatment.

Access to a translation service was available for patients who did not have English as their first language. Information on telephone interpretation was displayed on the patient information board which advised of the service in multiple languages. There had not been any requirement to use the service, so a test had been carried out to familiarise staff with the process. Patients were able to request a clinician of the same gender and would be signposted to Brize Norton or Benson dental centres.

Involvement in decisions about care and treatment

Patient feedback complimented staff on providing clear information and explanation to support patients with making informed decisions about treatment choices. The dental records we looked at indicated patients were involved in the decision making and recording of discussion about the treatment choices available. Diagrams on a board were used to explain root canal treatment or complex fillings. Other visual aids included pictures, photographs and showing the X-ray to the patient.

Are Services Responsive?

Responding to and meeting patients' needs

The practice took account of the principle that all regular serving service personnel were required to have a periodic dental inspection every 3 to 24-months depending on a dental risk assessment and rating for each patient. Patients could make routine appointments between their recall periods if they had any concerns about their oral health. The dentist maximised appointment times by completing as many treatments as possible for the patient during a single visit. Any urgent appointment requests would be accommodated on the same day. An emergency appointment was protected in the morning and staff reported that urgent requests for pain or trauma would be accommodated in the afternoon clinics when possible or referred to Benson or Brize Norton dental centres if no appointment was available.

Feedback from patients suggested they found that securing a routine appointment was a challenge. Five of the CQC comment cards included comments on the difficulty in securing an appointment. This was supported by comments from staff who highlighted that the patient list of 800 was being managed by a 0.4 whole time equivalent. Defence Primary Healthcare (DPHC) guidelines indicated that this should be a full-time post. Support had been requested to region, but no locum dentists had been provided. There was a dentist at Benson who had been allocated for 3-days a week but was a temporary healthcare worker and could therefore not work alone at Bicester (in accordance with DPHC policy). Region had advised that patients would need to travel but the Commanding Officer at Bicester was resistant to this arrangement. A discussion was planned with the Senior Dental Officer (SDO) at Abingdon Dental Centre to seek a resolution as the acting SDO was due to deploy in September 2025.

If there were any cancelled or missed appointments the practice would try to fill these using waiting lists of urgent and routine patients who were able to attend at short notice. The text messaging service had been introduced but was an automated system and was not being used to provide short notice communications. Mobile connection at Bicester was an ongoing issue so communication was a challenge.

Promoting equality

In line with the Equality Act 2010, an Equality Access Audit had been completed in April 2025. The audit followed the DPHC template but highlighted the main issue being that the dental centre was on the first floor of a building which did not have a lift. Egress on the first floor would not be suitable for patients or staff with reduced mobility due to the large step in front of the fire exit. The facilities did not have automatic doors at the entrance and all rooms were situated on the first floor of the building but there was no lift for patients if unable to use the stairs. As a result of the audit, a sign was positioned at the main entrance (visible from outside the building) that advised patients of accessible friendly practices within the region.

Staff had never encountered the need for a hearing loop at the reception desk. However, there was signage at the reception hatch and a device kept behind reception should it be required.

Access to the service

Information about the service, including opening hours and access to emergency out-of-hours treatment, was displayed on the front door, in the practice leaflet, on the practice SharePoint site and was included as part of the recorded message relayed by telephone when the practice was closed. Through the 'My Healthcare Hub,' a DPHC application used to advise patients on services available, patients could also access the information.

The backlog of appointment requests was significant, and this had the potential to impact on the dental fitness for deploying personnel. The acting SDO was also providing hygienist treatment as an alternative for patients having to travel to Brize Norton to see a hygienist.

Concerns and complaints

The SDO was the lead for complaints and was deputised by the practice manager. The practice manager was the named contact for compliments and suggestions. Complaints were managed in accordance with the DPHC policy. The team had all completed training that included the DPHC complaints' policy. A process was in place for managing complaints, including a register for written and verbal feedback. There had been no written or verbal complaint in the last 12-months. Staff were familiar with the process for managing complaints and this was supported by a written protocol. They were investigated and responded to appropriately and in a timely manner. Staff advised that any complaint would be discussed in a practice meeting and complaints was included as a standing agenda item.

Patients were made aware of the complaints process through the practice information leaflet and a display in the practice. The practice had a box in the waiting area. Quick response codes or 'QR' were included in the patient information leaflet and on the patient feedback board. Patients could use the QR codes to give feedback out of sight from the reception area with anonymity.

Are Services Well Led?

Governance arrangements

The Senior Dental Officer (SDO) had overall responsibility for the management and clinical leadership of the practice. The practice manager had the delegated responsibility for the day-to-day administration of the service. Staff were clear about current lines of accountability and secondary roles. They knew who they should approach if they had an issue that needed resolving. The SDO had overall responsibility for the management of risks for the service. These risks were fed into the regional risk register and in turn then from the regional headquarters to Defence Primary Healthcare (DPHC) headquarters.

The risk register as well as the business continuity plan were seen at the visit. There were a number of examples of risks that had been identified and actioned but not added to the register. For example, the flooring in the changing room needed replacing and a mirror was required in surgery 2 so that staff would be outside of the line of the beam when taking an X-ray. Some windows did not have safety locks (limit the opening), there was no shower in the changing room and no air conditioning in the reception area. The register required an overall review and monitoring on a regular basis for updates/compliance and changes. This had not been competed formally since a change in SDO.

A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were dental specific protocols and standard operating procedures (SOPs) that took account of current legislation and national guidance. Staff were familiar with these, and they referred to them throughout the inspection.

Staff told us that case discussion took place at practice meetings, and this forum was used to review any clinical specific policy changes, new SOPs and any new materials. However, the frequency of practice meetings did not follow the monthly schedule due to availability of staff and priority of seeing patients. Although the size of the team was small enough to provide some mitigation, the governance systems lacked formality and consistency. Capacity of the dental centre was impacting the work required with priority given to seeing patients. Although this was described as a temporary solution until a new SDO was recruited, it had been the arrangement since March 2025.

An Internal Assurance Review visit took place in May 2024. The practice was given a grading of ‘substantial assurance.’ A management action plan (MAP) was developed as a result and actions identified had been completed. Performance against military dental targets, complaints, staffing levels, staff training, audit activity, the risk register and significant events were all uploaded onto SharePoint and could be viewed by region, DPHC headquarters and anyone granted access. The Health Assurance Framework (HAF) was used as part of the practice manager handover, it was a live document, updated regularly by the practice. The SDO and the practice manager monitored the HAF for changes and updates were provided at the monthly practice meetings. This was also discussed at practice meetings, so all staff had an awareness of the document and its contents. The MAP was reviewed regularly and updated as actions were completed. The MAP was also monitored regularly by the Regional Headquarters and DPHC headquarters.

Staff told us that there were clear lines of communication within the practice and gave positive comments on the teamwork. Although the SDO and practice manager were responsible for the leadership and management of the practice, duties were distributed throughout the staff to ensure the correct subject matter expert had the correct role. The dental nurse was new into the role and still to complete their induction. Therefore, they were unable to take on the lead roles assigned to them until they had completed the probationary period.

All staff were encouraged to have input into the governance and assurance frameworks. Terms of reference were in place to clarify the responsibilities of those with lead roles. Practice meetings were planned every month although these had been held sporadically since the previous SDO left in December 2024; these meetings had an agenda and were minuted. All staff felt they had input and could speak freely as well as being listened to. Minutes were sighted at the visit and confirmed to include all the required standing agenda items. Staff felt supported and valued within the team but not within the wider organisation due to the time it was taking to make more permanent arrangements, in particular, a permanent SDO.

Information governance arrangements were in place and staff were aware of the importance of these in protecting patient personal information. Each member of staff had a login password to access the electronic systems and were not permitted to share their passwords with other staff. Measures were taken to ensure computers were secure and screens not accessible to patients or visitors to the building. Discussions with patients were held away from reception if requested. A reporting system was in place should a confidentiality breach occur (on the ASER system via the SDO). Staff had completed the Defence Information Management Passport training, data protection training and training in the Caldicott principles.

To address environmental sustainability, the practice aimed to reduce the use of paper through digitalisation. Recycling bins were in use for food waste and mixed recycling. Stock was effectively managed to reduce wastage. Wipeable boards were used for medical histories and chits, paper was recycled, and a re-usable bag was used for laundry.

Leadership, openness and transparency

The team worked well together with the collective aim to provide patients with a good standard of care. Staff described an open and transparent culture and were confident any concerns they raised would be addressed without judgement. Staff described leaders as supportive and considerate of the views of all staff.

Learning and improvement

Quality assurance processes to encourage learning and continuous improvement were a standing agenda at practice meetings and there was a log of quality improvement projects that included a text reminder service and the prescription log being transferred to being online. An audit calendar was in place to capture those not on the DPHC healthcare governance page and those not on the document management system. There were a number of quality improvement projects that had been initiated as a result of audit. These included a hygienist access audit in 2024 and a lab turnaround time audit in 2023. Notes audits had not been carried out. Although not required, regular audits of clinical record

keeping are considered good practice. Mandated audits such as infection, prevention and control were in-date but there had been no capacity to carry out any additional clinical auditing.

Staff received mid and end of year annual appraisal and these were up-to-date. These were supported by personal development plans tailored to individual staff members. Staff spoke positively about support given to complete their continued professional development in line with General Dental Council requirements. Staff were encouraged to set goals and areas for improvement and development, and this was completed in the 'My HR' app.

Practice seeks and acts on feedback from its patients, the public and staff

A quick response or 'QR' code was in the practice information leaflet for patients to use to leave feedback, there was also paper methods available too and staff were always available should the patient want to give verbal feedback. The General Practice Assurance and Quality (GPAQ) questionnaire had previously been used to review feedback. However, the practice manager had not summarised the data since the previous SDO had left so the most recent data provided was for the period August 2023 to August 2024. As the GPAQ is a live system, it means the information can also be accessed by the Regional Headquarters and DPHC Headquarters who can then conduct analysis for wider regional trends. Updates were then fed to the staff at practice meetings. A 'you said, we did' display board in the entrance corridor informed patients of action taken as a result of feedback. Examples included the provision of hygienist treatment at Bicester requested by multiple patients. This was temporarily being provided by the SDO, and a request had been submitted to the Chain of Command for a visiting hygienist. A text messaging service was in place to provide patients with a reminder of their appointment and to inform if an appointment needed to be rebooked.

The SDO listened to staff views and feedback at meetings and through informal discussions. Staff were encouraged to offer suggestions for improvements to the service and said these were listened to and acted on. A staff suggestion box was positioned discreetly so that anonymous feedback could be given. All staff had been invited to complete a climate assessment survey in December 2024. Anonymous feedback was sent to the Principal Dental Officer. Results were collated and any outcomes were discussed at regional meetings or training days. Whitespace events had not been held due to time constraints. Staff fed back that these would be welcomed.